STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

12/18/2015 PUBLIC NOTICE OF PROPOSED AMENDMENT TO RHODE ISLAND MEDICAID STATE PLAN

In accordance Rhode Island General Laws 42-35, notice is hereby given that the Executive Office of Health and Human Services (EOHHS) proposes to make the following amendment to the Rhode Island State Plan under Title XIX of the Social Security Act:

Reinventing Medicaid 2015:
Rhode Island Integrated Health Homes

As part of Governor Gina Raimondo's effort to reform Medicaid, the Working Group to Reinvent Medicaid issued an April report that recommended numerous initiatives to achieve financial savings in State Fiscal Year (SFY) 2016. The Governor introduced those recommendations in a budget article entitled, "The Reinventing Medicaid Act of 2015." The Rhode Island General Assembly passed the Reinventing Medicaid Act in June.

As a result of the Act's passage, EOHHS is seeking federal authority to implement several changes to the Medicaid program. This state plan amendment will substantially redesign the state's behavioral health homes to improve treatment and outcomes.

Changes included the following:

- Re-creation of Assertive Community Treatment (ACT). This redesign proposes an ACT for those identified to be in need as established in a standardized level of care/functionality assessment.
- Use of a standardized tool to identify functionality and guide level of care planning.
- Use of performance metrics tied to quality withholds and incentives.
- Unbundling of clinical services leading to greater efficiencies.
- Removing minimum contacts for IHH so that resources can be distributed to meet clients need
- Increased fee for services rates to increase provision of services which have been largely underutilized in the current structure.
- Movement in-plan enhances opportunities for state, plans and programs to establish alternative programming which will improve outcomes
- Integrating IHH and treatment services into the full MCO continuum of care will encourage effective system redesign with clinical and financial goals shared across State agencies, MCOs and CMHOs.

This proposed amendment is accessible on the EOHHS website at http://www.eohhs.ri.gov/ReferenceCenter/StatePlanAmendmentsand1115WaiverChanges.aspx or available in hard copy upon request (401-462-1965 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by January 18, 2016 to Darren J. McDonald, Executive Office of Health and Human Services, Hazard Building, 74 West Road, Cranston, RI, 02920, or darren.mcdonald@ohhs.ri.gov.

In accordance with the Rhode Island General Laws 42-35-3, an oral hearing will be granted on the proposed State Plan Amendment if requested by twenty-five (25) persons, an agency, or by an association having at least twenty-five (25) members. A request for an oral hearing must be made within thirty (30) days of this notice.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief, or handicap in acceptance for or provision of services or employment in its programs or activities.

Rhode Island Integrated Health Homes

Introduction:

The full integration of clients' medical and behavioral benefits into managed care creates new opportunities for further clinical integration across the continuum of care. This integration will allow integrated health homes (IHH) greater capacity to work with clients across all levels of care in order to achieve substantial clinical improvement. Services provided through IHHs and Assertive Community Treatment (ACT) are the fixed points of responsibility to coordinate and ensure the delivery of person-centered care, provide timely post-discharge follow-up, and improve patient health outcomes by addressing primary medical, specialist, and behavioral health care. Emphasis is placed on the monitoring of chronic conditions, as well as preventative and educational services focused on self-care, wellness, and recovery.

This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. These outcomes are achieved by adopting a whole-person approach to the consumer's needs and addressing the consumer's primary medical, specialist, and behavioral health care needs; and by providing the following timely and comprehensive services:

- Comprehensive Care Management;
- Care Coordination and Health Promotion;
- Comprehensive Transitional Care;
- Individual and Family Support Services; and
- Chronic Condition Management and Population Management.

IHH is built upon the evidence-based practices of the patient-centered medical home model. IHH builds linkages to other community social supports and enhances coordination of medical and behavioral healthcare in keeping with the needs of persons with multiple chronic illnesses. IHH is a service provided to community-based clients by professional mental health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. IHH teams monitor and provide medically necessary interventions to assist in the management of symptoms of illness as well as overall life situations, including accessing needed medical, social, educational, and other services necessary to meeting basic human needs.

Assertive Community Treatment (ACT) is a mental health program made up of a multidisciplinary staff who work as a team to provide the psychiatric treatment, rehabilitation, and support services clients need to achieve their goals. ACT services are tailored for each client to enable each to find and live in their own residence, to find and maintain work, to better manage symptoms, to involve community supports, to achieve individual goals, and to maintain optimism and recover. Unlike other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation programs or services. Rather, the ACT team is mobile and delivers services in community locations. Seventy-five percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for clients. The clients served have severe and persistent mental illnesses that significantly impact functioning. The ACT

teams are available to provide these necessary services 24 hours a day, seven days a week, 365 days a year.

Clients eligible for IHH services will meet diagnostic and functional criteria established by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). The required diagnoses are as follows:

Schizophrenia
Schizoaffective Disorder
Schizoid Personality Disorder
Bipolar Disorder
Major Depressive Disorder, recurrent
Obsessive-Compulsive Disorder
Borderline Personality Disorder
Delusional Disorder
Psychotic Disorder

Individuals will also be assessed for eligibility using the Daily Living Activities-Adult Mental Health—a standardized functional assessment of appropriateness for this level of intervention.

Provider Infrastructure:

Rhode Island has six CMHOs, which along with two other providers of specialty mental health services form a statewide, fully integrated, mental health delivery system, providing a comprehensive range of services to clients. All CMHOs and two specialty providers (Fellowship Health Resources, Inc. and Riverwood Mental Health Services) are licensed by the state under the author1ty of Rhode Island General Laws and operate in accordance with Rules and Regulations for the Licensing of Behavioral Healthcare Organizations. The six CMHOs, Fellowship Health Resources, Inc. and Riverwood Mental Health Services, will serve as designated providers of CMHO health home services. The six CMHOS, Fellowship Health Resources, Inc. and Riverwood Mental Health Services, represent the only entities that would meet eligibility requirements as a CMHO health home. Each CMHO health home is responsible for establishing an integrated service network statewide for coordinating service provision. CMHO health homes will have agreements, memorandums of understanding, and linkages with other health care providers, in-patient settings and long-term care settings that specify requirements for the establishment of coordinating comprehensive care.

The health home teams consist of individuals with expertise in several areas, any team member operating within his or her scope of practice, area of expertise and role or function on a health home team, may be called upon to coordinate care as necessary for an individual, (i.e., the bio-psychosocial assessment can only be conducted as described under Care Management; however, a community support professional operating in the role of a hospital liaison may provide transitional care, health promotion and individual and family support services, as an example).

Standards for CMHO health home providers specify that each health home indicate

how each provider will: structure team composition and member roles in CMHOs to achieve health home objectives and outcomes; coordinate with primary care (which could include co-location, embedded services, or the implementation of referral and follow-up procedures outlined in memoranda of understanding); formalize referral agreements with hospitals for comprehensive transitional care, and carry out health promotion activities.

CMHOs will be supported in transferring service delivery by participating in statewide learning activities. Given CMHOs' varying levels of experience with practice transformation approaches, the State will assess providers to determine learning needs. CMHOs will therefore participate in a variety of learning supports, up to and including learning collaboratives, specifically designed to instruct CMHOs to operate as health homes and provide care using a whole-person approach that integrates behavioral health, primary care and other needed services and supports. Learning activities will support providers of health home services in addressing the following components: - Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services; - Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines; - Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders; - Coordinate and provide access to mental health and substance abuse services; - Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings (transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care); - Coordinate and provide access to chronic disease management, including self-management support to individuals and their families; - Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services; - Coordinate and provide access to long-term care supports and services; - Develop a person-centered treatment plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services; - Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health home team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate, and; - Establish a continuous quality improvement program to collect and report on data that facilitates an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Service Definitions:

Comprehensive Care Management

Service Definition:
Comprehensive care management services are conducted with an individual and involve the identification, development and implementation of treatment plans that address the needs of the whole person. Family/Peer Supports can also be included in the process. The service involves the development of a treatment plan based on the completion of an assessment. A particular emphasis is the use of the multi-disciplinary teams including medical personnel who may or may

not be directly employed by the provider of the health home. The recipient of comprehensive care management is an individual with complex physical and behavioral health needs.

Ways Health IT Will Link:
CMHO will be required to achieve the following preliminary standards:

1. Program has structured information systems, policies, procedures, and practices to create, document, implement, and update a treatment plan for every consumer.

2. Health Home provider has a systematic process/system to follow-up on tests, treatments, services/referrals which is integrated into the consumer's treatment plan.

   Guidance: Programs have a system/process to identify, track, and proactively manage the care needs of consumers using up-to-date information. In order to coordinate and manage care, the program practice has a system in place to produce and track basic information about its consumer population, including a system to proactively coordinate/manage care of a consumer population with specific disease/health care needs.

3. The Program has a developed process and/or system which allows the consumer's health information and treatment plan to be accessible to the interdisciplinary provider team, and which allows for population management/identification of gaps in care including preventative services.

4. Programs are committed to work with Rhode Island's health information exchange system (CurrentCare) and be in compliance with any future version of the Statewide Policy Guidance regarding information, polices, standards, and technical approaches, governing health information exchange.

   Guidance: Provider is committed to promote, populate, use, and access data through the statewide health information exchange system. Provider is to implement the following tasks: Provider works with RI's Health Information Exchange to ensure they receive the technical assistance in regards to any of the above requirements.

5. Programs have the capability to share information with other providers and collect specific quality measures as required by EOHHS and CMS.

6. Program is able to use EOHHS and CMS quality measures as an accountability framework for assessing progress towards reducing avoidable health costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits, and providing timely post discharge follow-up care.

   Guidance: Provider is committed to and is engaged in utilizing quality measures to improve services.

Care Coordination and Health Promotion

Service Definition:

Each client will be assigned a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the person-centered treatment/care coordination plan, ensure plans are revised as necessary, and advocate for client rights and preferences. The case manager will collaborate with primary and specialty care providers as required. Additionally, the case manager will provide medical education to the client (e.g. educating through written materials, etc.).

The IHH team is responsible for managing clients' access to other healthcare providers and to act as a partner in encouraging compliance with treatment plans established by these providers. Health promotion activities are delivered by the team to engage clients in addressing healthy lifestyles and include services such as smoking cessation, nutrition, and stress management. The MCO and Community Mental Health Organization (CMHO) will meet regularly to review performance metrics and to collaborate on improvement plans. The IHH will coordinate with the client's Primary Care Physician (PCP). These additional plans will be incorporated into the patient's overall treatment plan.

Ways Health IT Will Link:
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   Guidance: Programs have a system/process to identify, track, and proactively manage the care needs of consumers using up-to-date information. In order to coordinate and manage care, the program practice has a system in place to produce and track basic information about its consumer population, including a system to proactively coordinate/manage care of a consumer population with specific disease/health care needs.

3. The Program has a developed process and/or system which allows the consumer's health information and treatment plan to be accessible to the interdisciplinary provider team, and which allows for population management/identification of gaps in care including preventative services.

4. Programs are committed to work with Rhode Island's health information exchange system and be in compliance with any future version of the Statewide Policy Guidance regarding information, polices, standards, and technical approaches, governing health information exchange.

   Guidance: Provider is committed to promote, populate, use, and access data through the statewide health information exchange system. Provider is to implement the following

tasks: Provider works with RI's Health Information Exchange to ensure they receive the technical assistance in regards to any of the above requirements.

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   Guidance: Provider is committed to and is engaged in utilizing quality measures to improve services.

Comprehensive Transitional Care

Service Definition:
The IHH team will ensure consumers are engaged by assuming an active role in discharge planning. The IHH team will ensure collaboration between consumers and medical professionals to reduce missed appointments and dissatisfaction with care. Specific functions include:

- Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs. For all medical and behavioral health inpatient stays, the IHH team conducts an on-site visit with client early in the hospital stay, participates in discharge planning, and leads the care transition until the client is stabilized.

- Upon hospital discharge (phone calls or home visit):
  - Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.
  - Assist consumer to identify and obtain answers to key questions or concerns.
  - Ensure the consumer understands their medications, can identify if their condition is worsening and how to respond, knows how to prevent a health problem from becoming worse, and has scheduled all follow-up appointments.
  - Prepare the consumer for what to expect if another care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).

- Identify linkages between long-term care and home and community-based services.

Ways Health IT Will Link:
The CMHO will be required to achieve the following preliminary standards:

1. Program has structured information systems, policies, procedures, and practices to create, document, implement, and update a treatment plan for every consumer.

2. Health Home provider has a systematic process/system to follow-up on tests, treatments, services/referrals which is integrated into the consumer's treatment plan.

Guidance: Programs have a system/process to identify, track, and proactively manage the consumers' care needs using up-to-date information. In order to coordinate and manage care, the program practice has a system in place to produce and track basic information about its consumer population, including a system to proactively coordinate/manage care of a consumer population with specific disease/health care needs.

3. The program has a developed process and/or system which allows the consumer's health information and treatment plan to be accessible to the interdisciplinary provider team of providers, and which allows for population management/identification of gaps in care including preventative services.

4. Programs are committed to work with Rhode Island's health information exchange system (CurrentCare) and be in compliance with any future version of the Statewide Policy Guidance regarding information, polices, standards, and technical approaches, governing health information exchange.

   Guidance: Provider is committed to promote, populate, use, and access data through the statewide health information exchange system. Provider is to work with RI's Health Information Exchange to ensure they receive the technical assistance in regards to any of the above requirements.

5. Programs have the capability to share information with other providers and collect specific quality measures as required by EOHHS and CMS.

6. Program is able to use EOHHS and CMS quality measures as an accountability framework for assessing progress towards reducing avoidable health costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits, and providing timely post discharge follow-up care.

   Guidance: Provider is committed to and is engaged in utilizing quality measures to improve services.

Individual and Family Support Services

Service Definition:
IHH team will provide practical help and support, advocacy, coordination, and direct assistance in helping clients to obtain medical and dental health care. Services include individualized education about the client's illness and service coordination for clients with children (e.g. services to help client fulfill parenting responsibilities, services to help client restore relationship with children, etc.).

IHH peer specialists will help consumers utilize support services in the community and encourage them in their recovery efforts by sharing their lived experience and perspective. Peer support validates clients' experiences, guides and encourages clients to take responsibility for their own recovery. In addition, peer supports will:

- Help clients establish a link to primary health care and health promotion activities,
- Assist clients in reducing high-risk behaviors and health-risk factors such as smoking, poor illness self-management, inadequate nutrition, and infrequent exercise,
- Assist clients in making behavioral changes leading to positive lifestyle improvement, and
- Help clients set and achieve a wellness or health goal using standardized programs such as Whole Health Action Maintenance (WHAM).

Ways Health IT Will Link:
The CMHO will be required to achieve the following preliminary standards:

1. Program has structured information systems, policies, procedures, and practices to create, document, implement, and update a treatment plan for every consumer.

2. Health Home provider has a systematic process/system to follow-up on tests, treatments, and services/referrals which is integrated into the consumer's treatment plan.

   Guidance: Programs have a system/process to identify, track, and manage the consumers' care needs by using up-to-date information. In order to coordinate and manage care, the program practice has a system in place to produce and track basic information about its consumer population, including a system to proactively coordinate/manage care of a consumer population with specific disease/health care needs.

3. The program has a developed process and/or system which allows the consumer's health information and treatment plan to be accessible to the interdisciplinary provider team, and which allows for population management/identification of gaps in care including preventative services.

4. Programs are committed to work with Rhode Island's health information exchange system (CurrentCare) and be in compliance with any future version of the Statewide Policy Guidance regarding information, polices, standards, and technical approaches, governing health information exchange.

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5. Programs have the capability to share information with other providers and collect specific quality measures as required by EOHHS and CMS.

6. Program is able to use EOHHS and CMS quality measures as an accountability framework for assessing progress towards reducing avoidable health costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits, and providing timely post discharge follow-up care.

Guidance: Provider is committed to and is engaged in utilizing quality measures to improve services.

Chronic Condition Management and Population Management

Service Definition:
The IHH team supports its consumers as they participate in managing the care they receive. Interventions provided under IHH may include, but are not limited to:

- Assisting in the development of symptom self-management, communication skills, and appropriate social networks to assist clients in gaining effective control over their psychiatric symptoms;

- Provide health education, counseling, and symptom management to enable client to be knowledgeable in the oversight of chronic medical illness as advised by the client's primary/specialty medical team;

- Maintaining up-to-date assessments and evaluations necessary to ensure the continuing availability of required services;

- Assisting the client in locating and effectively utilizing all necessary medical, social, and psychiatric community services;

- Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to manage their psychiatric and medical symptoms to live in the community. This includes:

    - Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling;
    - Teach money-management skills (e.g. budgeting and bill paying) and assist client assessing financial services (e.g. payeeship etc.).
    - Develop skills related to reliable transportation (help obtain driver's license, arrange for cabs, finds rides).
    - Provide individual supportive therapy (e.g. problem solving, role playing, modeling and support), social skill development, and assertive training to increase client social and interpersonal activities in community settings) e.g. plan, structure, and prompt social and leisure activities on evenings, weekends, and holidays, including direct support and coaching.

- Assistance with other activities necessary to maintain personal and medical stability in a community setting and to assist the client to gain mastery over their psychiatric symptoms or medical conditions and disabilities in the context of daily living. For example:

- Support the client to consistently adhere to their medication regimens, especially for clients who are unable to engage due to symptom impairment issues.
- Accompanying clients to and assisting them at pharmacies to obtain medications.
- Accompany consumers to medical appointments, facilitate medical follow up.
- Provide direct support and coaching to help clients socialize - structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support.

The IHH team will conduct the necessary analysis related to how well they are managing entire populations, based on measurable health outcomes and utilization. This information helps IHHs improve their care delivery system, to the benefit of each IHH clients receiving care.

Ways Health IT Will Link:
The CMHO will be required to achieve the following preliminary standards:

1. Program has structured information systems, policies, procedures, and practices to create, document, implement, and update a treatment plan for every consumer.

2. Health Home provider has a systematic process/system to follow-up on tests, treatments, and services/referrals which is integrated into the consumer's treatment plan.

   Guidance: Programs have a system/process to identify, track, and manage the consumers' care needs by using up-to-date information. In order to coordinate and manage care, the program practice has a system in place to produce and track basic information about its consumer population, including a system to proactively coordinate/manage care of a consumer population with specific disease/health care needs.

3. The program has a developed process and/or system which allows the consumer's health information and treatment plan to be accessible to the interdisciplinary provider team, and which allows for population management/identification of gaps in care including preventative services.

4. Programs are committed to work with Rhode Island's health information exchange system (CurrentCare) and be in compliance with any future version of the Statewide Policy Guidance regarding information, polices, standards, and technical approaches, governing health information exchange.

   Guidance: Provider is committed to promote, populate, use, and access data through the statewide health information exchange system. Provider is to work with RI's Health Information Exchange to ensure they receive the technical assistance in regards to any of the above requirements.

5. Programs have the capability to share information with other providers and collect specific quality measures as required by EOHHS and CMS.

6. Program is able to use EOHHS and CMS quality measures as an accountability framework for assessing progress towards reducing avoidable health costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits, and providing timely post discharge follow-up care.

Guidance: Provider is committed to and is engaged in utilizing quality measures to improve services.

Provider Standards:

Comprehensive Care Management

The IHH and ACT shall provide evidence of compliance with the following:

1. Service capacity and team composition; roles and responsibilities meet staffing requirements.

2. A comprehensive and culturally appropriate health assessment is used that yields both subjective and objective findings regarding the consumer's health needs.

3. The consumer's treatment plan clearly identifies primary, specialty, community networks and supports to address identified needs; along with family members and other supports involved in the consumer's care.

4. A consumer's treatment plan reflects the consumer's engagement level in goal setting, issue identification, self-management action, and the interventions to support self-management efforts to maintain health and wellness.

5. Service coordination activities use treatment guidelines that establish integrated clinical care pathways for health teams to provide organized and efficient care coordination across risk levels or health conditions.

6. The Program functions as the fixed point of responsibility for engaging and retaining consumers in care and monitoring individual and population health status to determine adherence or variance from recommended treatment guidelines.

7. Routine/periodic reassessment, using the DLA, conducted every 6 months at a minimum, to include reassessment of the care management process and the consumer's progress towards meeting clinical and person-centered health action plan goals.

8. The Program assumes primary responsibility for psychotropic medications, including administration; documentation of non-psychotropic medications prescribed by physicians and any medication adherence, side effects, issues etc.

9. The Program uses peer supports (certified Peer Recovery Specialists) and self-care programs to increase the consumer's knowledge about their health care conditions and to improve adherence to prevention and treatment activities.

10. Evidence that the outcome and evaluation tools being used by the health care team uses quality metrics, including assessment and survey results and utilization of services to monitor and evaluate the impact of interventions.

Care Coordination and Health Promotion

The medical record shall provide evidence that:

1. Each consumer on the Program's team has a dedicated case manager who has overall responsibility and accountability for coordinating all aspects of the consumer's care.

2. A Program has a relationship with the community agencies in its local area. To that end it can provide evidence that the case managers can converse with these agencies on an as-needed basis when there are changes in a consumer's condition.

3. A Program facilitates collaboration through the establishment of relationships with all members of consumer's interdisciplinary health team.

4. Policies, procedures and accountabilities (contractual or memos of understanding agreements) have been developed to support and define the roles and responsibilities for effective collaboration between primary care, specialists, behavioral health, long-term services and supports and community-based organizations.

5. A psychiatrist or APRN/Nurse Practitioner provides medical leadership to the implementation and coordination of program's activities by developing and maintaining working relationships with primary and specialty care providers including various inpatient and long-term care facilities.

6. Protocol has been developed for priority appointments for Program's consumers to behavioral health providers and services, and within the Program's provider network to avoid unnecessary or inappropriate utilization of emergency room, inpatient hospital and institutional services.

7. The Program's provider has a system to track and share consumer's patient care information and care needs across providers and to monitor consumer's outcomes and initiate changes in care, as necessary, to address consumer needs.

8. 24 hours/seven days a week availability to provide information/emergency consultation services to the consumer.

Comprehensive Transitional Care

The consumer's medical record shall provide evidence that:

1. A Program's case manager is an active participant in all phases of care transition, including timely access to follow-up care and post-hospital discharge (see metrics).

2. The Program's provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, residential/rehabilitation settings, and community-based services, to help ensure coordinated, safe transitions in care.

3. A notification system is in place with Managed Care Organizations to notify the Programs of a consumer's admission and/or discharge from an emergency room, inpatient unit, nursing home or residential/rehabilitation facility.

4. The Program collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing the consumer's ability to self-mange care and live safely in the community.

5. Care coordination is used when transitioning an individual from jail/prison into the community.

Individual and Family Support Services

The consumer's medical record shall:

1. Incorporate, through the consumer's treatment plan, the consumer and family preferences, education, support for self-management, self-help, recovery, and other resources as needed to implement the consumer's health action goals.

2. Identify and refer to resources that support the consumer in attaining the highest level of health and functioning in their families and in the community, including ensuring transportation to and from medically necessary services.

3. Demonstrate communication and information shared with consumers and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

Chronic Condition Management and Population Management

The consumer's medical record shall:

1. Identify available community-based resources discussed with consumers and evidence of actively managed appropriate referrals, demonstrate advocating for access to care and

services, and include evidence of the provision of coaching for consumers to engage in self-care and follow-up with required services.

2. Reflect policies, procedures, and accountabilities (through contractual or memos of understanding, affiliation agreements or quality service agreements) to support effective collaboration with community-based resources, which clearly define roles and responsibilities.

Monitoring:

To assess quality improvements and clinical outcomes, the State will collect clinical and quality of care data for the CMS Core Set of Measures and state-specific performance measures. These measures may include a combination of claims, administrative, and qualitative data. Data for each measure will be collected through defined quality processes aligned to state and provider benchmarks.
Attached are the IHH performance measures for each quarter followed by the CMS Core set of Measures.

IHH Year 1 Performance Measures: quarter data collected	Numerator	Denominator	Definition
Quarter 1 Incentive			
Completed DLA	# IHH eligible members during the measurement quarter who have had a completed DLA-20 within the last 6 months	# IHH eligible members during measurement quarter	% of IHH eligible members who have a completed DLA-20
Quarter 2 Incentive			

BMI	#IHH eligible members during the measurement quarter who have a documented BMI in the preceding 12 month period	# IHH eligible adults during measurement year (Note: Follow-up documentation to be included in Y2)	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 – 64 years BMI > or = 18.5 and < 25
Employment Rate	# IHH eligible members during the measurement quarter who are employed (full or part time) or in the armed forces as of 06/30/2016	#IHH eligible members during the measurement quarter (excluding IHH eligible members whose employment status is "retired" or "unknown")	% of IHH population that report part or full time employment
Discharge for Non-Treatment Adherence	Number of IHH eligible members during measurement quarter discharged for non-compliance or who terminate service prior to completion against clinical advice.	Number of IHH eligible members during measurement quarter (unknown data excluded from both)	% of IHH members during the measurement period discharged for non-treatment adherence
Quarter 3 Incentive			

Annual Physical Exam or Well Visit with PCP	# IHH eligible adults with a claim for an annual physical or well visit during the measurement year	# IHH eligible adults during measurement year	85% of population has Annual Physical Exam with PCP
Admits per 1000 for MH and SUD acute inpatient	#IHH eligible members during the measurement quarter with a psychiatric or substance use inpatient hospital admission (Not ASU/CSU)	Total number of adults in RI X 1000	Need to establish Baseline Measure and Target for Year 1
Patient Satisfaction Survey	Number of estimated attributed members who Strongly Agree or Agree with questions 7-12 of the OEI.	all estimated attributed members responding to the OEI (unknown data excluded from both when 1/3 or more of measures are missing).	Questions 7-12- % Responses Strongly Agree or Agree
Quarter 4 Incentive			
Mental Health Inpatient After Care Follow Up 3 Days	# IHH eligible adults who have a face to face visit with any member of the IHH team within 3 business days of a psychiatric hospital discharge (not including discharge date)	# IHH eligible adults with an inpatient psychiatric hospitalization during measurement year	90% of members who have a MH Inpatient Admission will receive 1 face to face contact by an IHH member within 3 business days of discharge
Mental Health Inpatient After Care Follow Up 7 Days	Number of adults receiving inpatient care	Number of adults who had an encounter with a MH Practitioner or Prescriber within 7 business days of discharge	Follow HEDIS specs for members who received an appointment by an MH Practitioner or Prescriber within 7 business days of discharge

Hospital 30-Day Readmissions All Cause Med, Surg, BH	Number of adults admitted to a hospital for any reason	Number of adults readmitted to a hospital 30 days after discharge from a hospital admission	The percentage of acute inpatient stays that were followed by a readmission within 30 days for any reason in adults ages 18 and older.
Total Cost of Care	Total cost of care for all adults itemized by plan and unenrolled		Identify decrease in total cost of care from SFY15 to SFY16

IHH Year 1 Monitoring Measures	Numerator	Denominator	Definition
Stable Housing	Number of estimated attributed members who are living in private, public or residential settings.	All estimated attributed members (unknown data excluded from both).	% of population who report stable housing (Private/Subsidized)

Smoking Cessation	Rate 1: Screening for tobacco use in patients with serious mental illness during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user. Rate 2: Screening for tobacco use in patients with alcohol or other drug dependence during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user.	Rate 1: All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year. Rate 2: All patients 18 years of age or older as of December 31 of the measurement year with any diagnosis of alcohol or other drug dependence during the measurement year.	75% of members referred smoking cessation counseling/medication evaluation (NQF Specs)
Acuity Level Transition	1.) # ACT clients in prior month in IHH or FFS in current month 2.) # IHH clients in prior month in ACT or FFS in current month 3.) # FFS clients in prior month in IHH or ACT in current month	Admits and discharges not included	% of members who Transition from High to Moderate or Low Acuity & % of members who Transition from Low or Moderate Acuity to High
ED Visits/1000	Number of ED visits	Number of enrollee months	Rate of ED visits per 1,000 enrollee months among HH Enrollees. A total rate as well as rates for the following age cohorts should be reported: 0-17, 18-64 and 65+.
Inpatient Average Length of Stay	UHC & NHP please provide numerator methodology	UHC & NHP please provide denominator methodology	Average Length of Stay for Inpatient (by Medical, MH, & SUD)

Comprehensive Diabetes Care Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	# IHH eligible clients whose most recent HbA1c level is greater than 9.0% (poor control) during the measurement year.	# IHH eligible clients with a diagnosis of diabetes (excluding gestational or steroid induced diabetes)	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.
Screening for Clinical Depression and Follow Up	All patients age 12 and older	# of patients screened for clinical depression on the date of encounter using an age-appropriate standardized depression screening tool, and if positive, a follow up plan is documented on the date of the positive screen.	Percentage of Health Home enrollee age 12 and older screened for clinical depression using an age appropriate standardize depression screening tool, and if positive, a follow up plan is documented on the date of the positive screen.
Controlling High Blood Pressure	Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.	The number of patients in the denominator where recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. Single rate is reported.
Care Transition-Timely Transmission of Transition Record	All patients, regardless of age, discharged from an inpatient facility (e.g, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Percentage of discharges from an inpatient facility to home or any other site of care which a transition record was transmitted to the facility, home health provider or primary physician/other health professional designated for follow up care within 24 hours of discharge among health home enrollees

Initiation & Engagement of Alcohol and other Drug Dependence Treatment	Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).	Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).	Percentage of health home enrollees age 13 and older with a new episode of alcohol or other drug dependence who: initiated treatment through an inpatient admission, outpatient visit, IOP, or PHP within 14 days of diagnosis.Initiated treatment and who had 2+ services with a diagnosis of AOD within 30 days of initiation visit.
Prevention Quality Indicator (PQI 92: Chronic Conditions Composite	Population ages 18 years and older in metropolitan area† or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.	Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rulesfor the numerator in any of the following PQIs:• PQI #1 Diabetes Short-Term Complications Admission Rate• PQI #3 Diabetes Long-Term Complications Admission Rate• PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older AdultsAdmission Rate• PQI #7 Hypertension Admission Rate• PQI #8 Heart Failure Admission Rate• PQI #13 Angina Without Procedure Admission Rate• PQI #14 Uncontrolled Diabetes Admission Rate• PQI #15 Asthma in Younger Adults Admission Rate• PQI #16 Lower-Extremity Amputation among Patients with Diabetes RateDischarges that meet the inclusion and exclusion rules for the numerator in more than one ofthe above	Number of hospital admissions for chronic conditions per 100,000 member months for health home enrollee age 18 and older.

		PQIs are counted only once in the composite numerator.	
Inpatient Utilization	Inpatient utilization by discharge date, rather than by admission date and include all discharge that occurred during the measurement year.	Number of enrollee months	Rate of acute inpatient care and services (total, maternity, mental and BH, surgery and medicine) per 1,000 enrollee months among HH enrollees. A total rate as well as rates for the following age cohorts should be reported: 0-17, 18-64 and 65+.
Nursing Facility Utilization			The number of admissions to a nursing facility from the community that results in a short term (less than 101 days) or long term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollment months. A total rate as well as rate for the 18-64 age cohort and 65 and older age cohort should be reported.

Payment Methodology:

Per Diem Rate to CMHO for Integrated Health Home (IHH) and Assertive Community Treatment (ACT)

1. The State will establish a fee structure designed to enlist participation of a sufficient number of providers in the IHH and ACT program so that eligible persons can receive the services included in the plan, at least to the extent that these are available to the general population.
2. Providers must be Community Mental Health Centers or other private, not-for-profit providers of mental health services who are licensed by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).
3. All providers must conform to the requirements of the current Rules and Regulations for the Licensing of Behavioral Healthcare Organizations, and all other applicable state and local fire and safety codes and ordinances.
4. Providers must agree to contract and accept the rates paid by the Managed Care Organization as established with the Executive Office of Health and Human Service (EOHHS) and BHDDH as the sole and complete payment in full for services delivered to beneficiaries, except for any potential payments made from the beneficiary's applied income, authorized co-payments, or cost sharing spend down liability.
5. Providers must be enrolled in the RI Medicaid Program, have a contract with the Managed Care Organizations and agree to meet all requirements, such as, timely access to care and matching beneficiaries service needs.
6. The State will not include the cost of room and board or for non-Medicaid services as a component of the rate for services authorized by this section of the state plan.

7. The State will pay for services under this section on the basis of the methodology described in 12-14 of this document.
8. The amount of time allocated to IHH and ACT for any individual staff member is reflective of the actual time that staff member is expected to spend providing reimbursable IHH and ACT services to Medicaid recipients.
9. Providers will be required to collect and submit complete encounter data for all IHH/ACT claims on a monthly basis utilizing standard Medicaid coding and units in an electronic format to be determined by EOHHS, BHDDH and Managed Care Organizations. Six months after the effective date of this SPA and following the receipt of encounter data, the state will conduct an analysis of the data to develop recipient profiles, study service patterns, and analyze program costs vs. services received by recipients, for potential adjustments to the case rate as well as for consideration of alternative payment methodologies.
Analysis will be conducted annually after the first six month review.
10. The State assures that IHH and ACT services under this submission will be separate and distinct and that duplicate payment will not be made for similar services available under other program authorities.
11. The rates were set as of January 1, 2016 and are effective through the state fiscal year, pending additional analysis for services. All rates are published on the RI EOHHS website at http://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/FeeSchedules/tabid/170/Default.aspx.

12. Basis for IHH Methodology for IHH:

The process is based on a CMS approved methodology that utilizes reliable estimates of the actual costs to the provider agencies for staff and operating/support and then feeding those costs into a fee model. The process also included the development of a standard core IHH team composition and suggested caseload based on estimates of available staff hours and client need.

Flexibility is given to the providers for the costs of the entire team. Ten positions are noted as core expectations that consists of one (1) Master's level coordinator, two (2) registered nurses, one (1) hospital liaison, five (5) CPST specialists and one (1) peer specialist.
Agencies will also be able to flex staff by need to certain teams. Agencies are still accountable to the entire number of staff, cost and salaries for all positions for Health Homes of the agency.

Any deviation from the model must have clinical and financial justification that is approved by BHDDH, the state Mental Health Authority. The goal is to give providers flexibility so that providers are able to manage the team to obtain the outcomes.

Staffing Model (per 200 clients):

Title	FTE
Master's Level Program Director	1
Registered Nurse	2
Hospital Liaison	1

CPST Specialist	5- 6
Peer Specialist	1
Medical Assistant	1 (optional)

	IHH				
	OCCUPANCY	100.0%			
	CLIENTS	200			
Program Staff:					
Qualifications:			FTE	Cost/FTE	Total Cost
Master's Level Coordinator			1.0	$78,817	$78,817
Registered Nurse			2.0	$81,500	$81,500
Hospital Liaison			1.0	$44,200	$44,200
CPST Specialist BA			6.0	$44,200	$44,200
Peer Specialist			1.0	$43,711	$43,711
Medical Assistant			1.0	$39,738	$39,738
					$634,666
			12.0		
	Fringe (Included in base cost)				0
Total base staff cost					$634,666
Total all staff cost					$634,666
Total administration and operating at state average				40%	$253,866
Total all costs					$888,532
Per diem:			$12.17		
PMPM			$370.22		

13. **Basis of Methodology for ACT:**

The State has reviewed ACT rates across the country and we have done a cost base review with our providers to determine the rate. Providers report that due to the intensity and the extended hours of the program; and the additional responsibility of providing an integrated health home

service to our most vulnerable population; salaries and wages that are typical for these positons are increased. State and Managed Care oversight for model fidelity will be implemented to assure outcomes.

Rhode Island has compared our ACT rates to other states providing just ACT services. For example, New York has rates between $1482-1716 per month, Nebraska is $1311-$1396 per month, North Carolina is the lowest at $1181.28 per month and Maryland is $1183.34 per month. Rhode Island's rate is $1267 per month and was reviewed with providers of 12.75 staff per 100 clients. The per diem will be $41.65.

Required Staffing Model per 100 clients:

TITLE	FTE
Program Director (LICSW, LMHC, LMFT, RN)	1
Registered Nurse	2
Master's Level Clinician	1
Vocational Specialist (BA level)	1
Substance Use Disorder Specialist (BA level)	2
CPST Specialist	4
Peer Specialist	1
Psychiatrist	.75

14. Payment Methodology Withhold:

All CMHOs will be required to report to the MCOs and RI Medicaid on a quarterly basis on a set of Year 1 required metrics. EOHHS and BHDDH support the importance of standardized reporting on outcome measures to ensure providers are increasing quality so clients make gains in overall health.

CMHO's will receive 90% of IHH and 90% of the health home services imbedded in the ACT rate. If the CMHO is able to demonstrate meeting the minimum quarterly reporting requirements and identified quality thresholds, the CMHC will receive the additional 10% payment from the MCOs. The 10% payment will be reconciled after all reports are received and approved by BHDDH and the Managed Care Organizations.

Attached are the performance metrics for the withhold

IHH Year 1 Performance Measures: quarter data collected	Numerator	Denominator	Definition
Quarter 1 Incentive			
Completed DLA	# IHH eligible members during the measurement quarter who have had a completed DLA-20 within the last 6 months	# IHH eligible members during measurement quarter	% of IHH eligible members who have a completed DLA-20
Quarter 2 Incentive			
BMI	#IHH eligible members during the measurement quarter who have a documented BMI in the preceding 12 month period	# IHH eligible adults during measurement year (Note: Follow-up documentation to be included in Y2)	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 – 64 years BMI > or = 18.5 and < 25

Employment Rate	# IHH eligible members during the measurement quarter who are employed (full or part time) or in the armed forces as of 06/30/2016	#IHH eligible members during the measurement quarter (excluding IHH eligible members whose employment status is "retired" or "unknown")	% of IHH population that report part or full time employment
Discharge for Non-Treatment Adherence	Number of IHH eligible members during measurement quarter discharged for non-compliance or who terminate service prior to completion against clinical advice.	Number of IHH eligible members during measurement quarter (unknown data excluded from both)	% of IHH members during the measurement period discharged for non-treatment adherence
Quarter 3 Incentive			
Annual Physical Exam or Well Visit with PCP	# IHH eligible adults with a claim for an annual physical or well visit during the measurement year	# IHH eligible adults during measurement year	85% of population has Annual Physical Exam with PCP
Admits per 1000 for MH and SUD acute inpatient	#IHH eligible members during the measurement quarter with a psychiatric or substance use inpatient hospital admission (Not ASU/CSU)	Total number of adults in RI X 1000	Need to establish Baseline Measure and Target for Year 1
Patient Satisfaction Survey	Number of estimated attributed members who Strongly Agree or Agree with questions 7-12 of the OEI.	all estimated attributed members responding to the OEI (unknown data excluded from both when 1/3 or more of measures are missing).	Questions 7-12- % Responses Strongly Agree or Agree
Quarter 4 Incentive			

Mental Health Inpatient After Care Follow Up 3 Days	# IHH eligible adults who have a face to face visit with any member of the IHH team within 3 business days of a psychiatric hospital discharge (not including discharge date)	# IHH eligible adults with an inpatient psychiatric hospitalization during measurement year	90% of members who have a MH Inpatient Admission will receive 1 face to face contact by an IHH member within 3 business days of discharge
Mental Health Inpatient After Care Follow Up 7 Days	Number of adults receiving inpatient care	Number of adults who had an encounter with a MH Practitioner or Prescriber within 7 business days of discharge	Follow HEDIS specs for members who received an appointment by an MH Practitioner or Prescriber within 7 business days of discharge
Hospital 30-Day Readmissions All Cause Med, Surg, BH	Number of adults admitted to a hospital for any reason	Number of adults readmitted to a hospital 30 days after discharge from a hospital admission	The percentage of acute inpatient stays that were followed by a readmission within 30 days for any reason in adults ages 18 and older.
Total Cost of Care	Total cost of care for all adults itemized by plan and unenrolled		Identify decrease in total cost of care from SFY15 to SFY16